

Completing Your Kentucky Immunization Registry Enrollment

Page 1 - Instruction Sheet

Page 2 - Provider details

Please complete all fields- if you do not understand any part of the form, please feel free to call or email the Kentucky Immunization Registry Help Desk.

Page 3 – User Accounts

“Login Users”

- **Signed User Confidentiality Agreements must be received before access will be provided.** Any and all staff members that may need access to Kentucky Immunization Registry (KYIR) must each read and complete a *User Confidentiality Agreement* form to establish a User Account. Please feel free to make copies as needed.
 - ✓ Please note: **only the signature page of the User Confidentiality Agreement needs to be submitted.** Please retain the “agreement page” for reference.
- **It is VERY important that each user provide an email address where they can be reached-** they will be placed in our User Distribution List and will receive messages regarding KYIR and the vaccine world. Please provide work-issued email addresses if possible. Please also make sure your computer network accepts our emails (sent from KYIRHelpdesk@ky.gov).

Adding Additional Users

- Please retain a blank User Confidentiality Agreement form for use in adding additional users after being established as a KYIR provider. Please mail or fax completed user forms to the address/fax listed on the forms.

Signature of Provider Contact: Choose an individual to be the official “KYIR Contact” in your office and have them sign and date the bottom of Page 3. They will be the first point of contact in any future KYIR correspondence.

Submitting the application: Please mail or fax the completed application to the address/fax at the bottom of Page 3. Please allow 10 business days for processing.

Office/Facility Enrollment Form

Please fill out this form as completely as possible. This information is used to establish a Kentucky Immunization Registry account for your organization. Please be sure your provider contact signs and dates page 3 before submitting. If you have questions regarding this form, please contact the KYIR Help Desk at (502)564-0038 or KYIRHelpdesk@ky.gov.

Provider (Practice) Name:

Provider Mailing Address:

Street

City

State

Zip Code

Provider Contact Person:

Title:

Business Phone:

Fax #:

E-mail address:

Provider Type:

(check only one)

- ☐ Correctional Facility
☐ General Practice
☐ LHA/County Health
☐ Pediatrics
☐ Urgent Care

- ☐ Dialysis Center
☐ Health Care Org./Ins. Co.
☐ Non-Profit/Free Clinic
☐ Pharmacy
☐ WIC

- ☐ Emergency (ER)
☐ Home Care Services
☐ Nursing Home/Hospice
☐ School/School District

- ☐ Employee Health
☐ Hospital
☐ Ob/Gyn/Women's
☐ Tribal Health Center

Does your office give immunizations? (check only one)

☐ Y* ☐ N

*If "Y" is checked, please choose either "Type 2" or "Type 3" under Usage Type below

Usage Type: (check only one)

☐ **View Only** (cannot enter data or make changes to data) If checked, skip to page 3 signature, and complete User Confidentiality Agreements

☐ **HEDIS** (can only upload & retrieve HEDIS data) If checked, skip to page 3 signature, and complete User Confidentiality Agreements

☐ **Type 2 – Captures vaccine details (such as lot number, expiration date, etc.)**

These providers must specify manufacturers/lot numbers for vaccines prior to documenting vaccinations

☐ **Type 3 – Full Inventory Management-for Vaccines for Children Program (VFC) providers only**

These providers must specify manufacturers/lot numbers for vaccines in the On-Hand screen and manage the quantities of vaccines in stock

Vaccines For Children (VFC) (check only if enrolled in VFC Program)

☐ VFC Provider? If yes...VFC Effective Date? _____ VFC Pin #? _____

Vaccine Funding Sources (please check all that apply)

☐ VFC ☐ Private ☐ Other: _____



User Accounts

"Log in Users"

Any and all staff members that may need access to KYIR must each read and complete a User Confidentiality Agreement (CHFS219) to establish a User Account. Please make copies as needed.

*****Signed User Confidentiality Agreements must be received before access will be provided. *****

1)	<hr/>	<hr/>	<hr/>	<hr/>
	Name	Title	Office Name(s)	Email Address
2)	<hr/>	<hr/>	<hr/>	<hr/>
	Name	Title	Office Name(s)	Email Address
3)	<hr/>	<hr/>	<hr/>	<hr/>
	Name	Title	Office Name(s)	Email Address
4)	<hr/>	<hr/>	<hr/>	<hr/>
	Name	Title	Office Name(s)	Email Address
5)	<hr/>	<hr/>	<hr/>	<hr/>
	Name	Title	Office Name(s)	Email Address

(If more than 5, attach separate sheet)

Signature of Provider Contact

Date Signed

Please complete this form and return to:

Kentucky Immunization Program-KYIR Helpdesk
275 East Main Street, HS2E-B
Frankfort, KY 40621
Phone: 502-564-0038
Fax: 502-564-4760
E-mail: KYIRHelpdesk@ky.gov

For Office Use Only:

Date Received: _____

Received By: _____

Date KYIR Account Est: _____

Completed By: _____

